



**HUMAN RESOURCES
& DEVELOPMENT**
TULARE COUNTY

Dependent Verification Form

Employee's Name: _____

Employee ID: _____

Social Security Number: _____

Please submit this form with the appropriate documentation for each of your covered dependents. Attach the documents to this form using a staple or paper clip.

Dependent Name		Verification Enclosed		
		Current Tax Return	Marriage License	Birth Certificates
Spouse		<input type="checkbox"/>	<input type="checkbox"/>	
Dependent		<input type="checkbox"/>		<input type="checkbox"/>
Dependent		<input type="checkbox"/>		<input type="checkbox"/>
Dependent		<input type="checkbox"/>		<input type="checkbox"/>
Dependent		<input type="checkbox"/>		<input type="checkbox"/>

I have enclosed the appropriate documentation for each of my covered dependents as indicated above. I understand that any dependent not verified will be considered ineligible for coverage under Tulare County's Health Plan and removed from my coverage. I further understand that ineligible dependents removed as a result of this audit cannot re-enroll as my dependent in any Tulare County Health Plan.

Employee's Signature

Date

Mail: Human Resources & Development
Benefits Department
2900 W Burrel Ave
Visalia, CA 93291

Fax: (559) 730-2597

Scan & Email: OEHealth@co.tulare.ca.us